

**STATE OF IDAHO**  
**Department of Administration – Office of Group Insurance**  
**IDAHO FLEX**  
**Election Form for the period July 1, 2005 through June 30, 2006**

<b>Name:</b>			<b>SSN:</b>		
<b>Mailing Address:</b>					
<b>City:</b>		<b>State:</b>		<b>Zip:</b>	
<b>Home Phone #:</b>			<b>Agency Name:</b>		
<b>Email Address:</b>			<b>Work Phone #:</b>		
<b>Date of Hire:</b>					

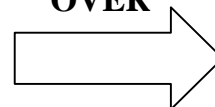
**Annual Election:** Medical FSA and Dependent Care FSA allow you to set aside PRE-TAX dollars for reimbursement. Indicate below the pay period and annual amounts you would like to contribute to each account:

\$ _____ / Per Pay Period  \$ _____ / Per Year	<b><u>Medical FSA Election</u></b> Minimum \$5.00, Maximum \$111.11 per pay period, not to exceed \$3,000 per year	Reimbursement for out-of-pocket medical expenses for you, your spouse and your dependents. Some qualifying expenses include: dental, vision, contacts, prescriptions, orthodontia, deductibles and co-pays.
\$ _____ / Per Pay Period  \$ _____ / Per Year	<b><u>Dependent Care FSA Election</u></b> Minimum \$5.00, Maximum \$184.89 per pay period, not to exceed \$4,992 per year	Reimbursement for dependent care expenses for dependents under the age of 13 or incapable of self-care. Care may be provided by an individual or licensed day care facility for full time, after school, or summer care. Care must be necessary for you and your spouse (if applicable) to be employed or attend school full-time.

I understand that:

- \* I am authorizing and directing my employer to reduce my salary by the amount indicated above. Such reduction, considered as an elective contribution under the State of Idaho's benefits program, shall commence with my first check on or after the effective date and will be taken from each check throughout the PLAN YEAR. **(ALL PLAN YEARS will be for twelve-month periods commencing on each July 1.)**
- \* The Annual Election remains in effect for the entire Plan Year unless I experience a "change in status" with regard to the Health FSA and a "change in family status" in regard to my Dependent Care FSA. These changes include such events as: change in marital status; change in number of dependents; or termination or commencement of employment. Specifics regarding changes in status are outlined in the Summary Plan Description. All election changes must be necessitated by and consistent with the change and notification must be made within 30 days to the administrator of the Plan. Only increases are allowed for MRA family status changes; no mid-year reductions are permitted, and are subject to the pay period maximum.
- \* Eligibility requirements are: Ten months of continuous State of Idaho service as of July 1 Plan Year start date and eligible to be enrolled in one of the State's medical plans. No minimum age.
- \* Any amounts that are not used during the Plan Year to reimburse qualifying expenses will be forfeited in accordance with current plan provisions and tax laws.
- \* Reimbursements will be available only for qualifying expenses as described by the Internal Revenue Service. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I agree to indemnify and reimburse the Employer on demand for any liability the Employer may incur for failure to withhold federal, state or social security tax from any reimbursement I receive for a non-qualifying expense.
- \* The guidelines for the administration and compliance of the Plan are outlined in the Employee Group Insurance Handbook and the FSA plan document (contract) located at [www2.state.id.us/adm/insurance/handbook\\_summary.htm](http://www2.state.id.us/adm/insurance/handbook_summary.htm).
- \* A monthly administrative fee of \$3.30 per participant will be withheld from your account each month.

**OVER**



## Idaho Flex – Benefits Rules and Regulations

Idaho Flex has three benefits available:

- A) Payment of Group Health and Dental Premiums with pretax dollars (existing Premium Only Plan)
- B) Medical Reimbursement Account
- C) Dependent Care Reimbursement Account

You may choose among these features. You will be subject to the rules and regulations of the plan, as summarized in employee handouts and found in the official plan document, which is available for your review. The front of this form is for election of reimbursement account benefits only. Deductions from your pay to fund these accounts will only be made if you complete, sign and file this form with your benefits administrator.

**Deductions for your share of health and dental premiums will be made automatically on a pretax basis; do not include these in your Medical Reimbursement Account.**

With all of these features, there are some **RULES** that must be followed to keep the plan in compliance with IRS regulations:

Your choice will be in effect for the entire Plan Year (July 1 through June 30). You may add, drop or change this coverage annually at enrollment or when any of the following family status changes occur:

Marriage	Death
Divorce	Birth or Adoption of a Dependent
Significant Change in Your Employment Status	Significant Change in Your Spouse's Employment Status

Any changes you wish to make must be consistent with your change in family status and must be made within 31 days of the event. You may increase your contributions, but reductions during the Plan Year are not permitted.

**With the Medical Reimbursement Account, these rules must be followed:**

- Health-related expenses are reimbursable if they can be considered "deductible" medical expenses on your tax return as defined under Section 213(d). Insurance premiums not paid through State-sponsored Health/Dental Plans and unnecessary cosmetic surgeries are ineligible expenses.
- You claims will be paid for the amount of your "out-of-pocket" expense up to your annual election, less previous claims paid.
- If you terminate employment, you may submit claims for expenses incurred prior to your termination only.
- You may continue to participate in this plan after termination, but on an after-tax basis through COBRA.

**With the Dependent Care Reimbursement Account, these rules must be followed:**

- Dependent care must be necessary for you and your spouse to be employed or attend school full-time.
- Dependent care expenses must be for your dependent child under age 13 or other dependents, such as a physically or mentally handicapped relative or household member who is unable to care for himself and over half of whose support you pay.
- You can contribute up to the maximum per year if you are a single parent or married and filing a joint return. This maximum is the total family contribution allowable. Your maximum may be lower if:
  - you or your spouse earns less than \$5,000.
  - you or your spouse is a full-time student or incapable of self-care; or
  - you are married but file a separate federal tax return.

See your benefits representative if any of these exceptions apply.

- Care cannot be provided by your spouse or anyone you claim as a tax dependent.
- You cannot claim the same day-care expenses reimbursed under this plan as a tax credit.
- Claims will be paid for the amount of your expense up to the amount of your account balance.
- If you terminate employment, you may continue to file for expenses you incur through the end of the Plan Year.
- You will be required to identify the person performing the child care services to the IRS by providing his/her federal I.D. number or social security number.

For both Medical and Dependent Care Reimbursement Accounts you will have until September 30 to file claims for expenses incurred during the Plan Year. Any money left in your accounts after September 30 for the prior Plan Year, after you have claimed all of your expenses for that year, will not be reimbursed to you. IRS regards the date of a claim as being when the service is rendered, not when you actually pay the bill.

Because amounts contributed through the various Idaho Flex features are not subject to social security taxes, a plan participant may receive slightly less social security at retirement.

Employee Signature:	Date:
State Agency Payroll Representative Signature:	Effective Date (if other than July 1, 2005):